STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 00 B. WING	04/24/2013

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F000000	This visit was for a Recertification and State Licensure Survey. Survey Dates: April 15, 16, 17, 18, 19, 22, 23, and 24, 2013. Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 Survey Team: Heather Lay, RN - TC (April 15, 16, 17, 18, 19, 22, 23, and 24, 2013) Lori Brettnacher, RN (April 15, 16, 17, 18, 19, 23, and 24, 2013) Census Bed Type: SNF: 0 SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 8 Medicaid: 59 Other: 14 Total: 81 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 05/24/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality Review completed 5/1/13 by Brenda Nunan, RN.			

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F000156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide the required Medicare liability notices for two of three residents who received Medicare funds and were discharged prior to the allotted Medicare days allowed (Resident #104 and Resident #98). Findings include: 1. Resident #104's record was reviewed on 4/24/2013 at 10:44 A.M. Resident #104 was admitted to the facility on 11/16/2012 and discharged on 11/28/12. During this time she was eligible for Medicare funds. During an interview on 4/23/2013 at 2:00 P.M., the Social Service Director (SSD), indicated a liability notice should have been provided to Resident #104 because she was discharged prior to her allotted Medicare funds/days ran out. However, she was unable to provide documentation which indicated the required liability notice was given to her. 2. Resident #98's record was reviewed on 4/24/2013 at 10:48 P.M. Resident #98 was admitted to the	F000156	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #104 and #98 no longer reside at facility. · Resident #104 was eligible for Medicare funds during her stay, and Medicare was the primary payer during her stay. Resident #104 was not issued a liability notice prior to her discharge because resident, who is her own responsible party, notified staff on 11/28/12 that she was leaving that day. No notice was provided to facility and discharge was upon resident's request. Resident has been gone for more than 60 days; therefore she would receive her full 100 Medicare benefit days at this time. · Resident #98 was eligible for Medicare funds during her stay, and Medicare was the primary payer during her stay. Resident #98 was not issued a liability notice prior to her discharge because discharge was upon resident request, with less than 48 hours notice. Resident #98 has since passed and letter can no longer be sent. **How will you identify other residents having the potential to be affected by the same deficient will be identified** · Residents who have Medicare Part A and Part B have the potential to be affected by the alleged	05/24/2013

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	facility on 7/20/2012 and discharged on 10/30/2012. During this time she was eligible for Medicare funds. During an interview on 4/23/2013 at 2:00 P.M., the Social Service Director (SSD), indicated a liability notice should have been provided to Resident #98 because she was discharged before her allotted Medicare funds/days ran out. However, she was unable to provide documentation which indicated the required liability notice was given to her. 3.1-(4)(f)(3)		deficient practice. · Notice of Medicare Non-Coverage notices will be given to residents with traditional Medicare when they end their Part A stay with benefit days remaining. This will be completed in person, via telephone, or through certified mail. · Audit of NOMNC will be completed by SSD/designee by 5/24/13 to ensure all NOMNC notices were delivered per Medicare guidelines. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Notice of Medicare Non-Coverage notices will be given to residents with traditional Medicare when they end their Part A stay with benefit days remaining. This will be completed in person, via telephone, or through certified mail. · Social Service Director and Memory Care Coordinator will be re-educated by Social Service Consultant by 05/24/2013. · Upcoming discharges will be discussed in morning meeting/discharge plan meetings to ensure timely delivery of NOMNC letters. IDT will review upcoming NOMNC letters sent. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**	

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			· To ensure compliance, the SSD/Designee is responsible for the completion of the Notice of Medicare Non Coverage CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. · Social Service Director and Memory Care Coordinator will be re-educated by Social Service Consultant by 05/24/2013.	

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F000225	**What corrective action(s) will be**	05/24/2013

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	review, the facility failed to report all allegations of abuse, complete a thorough investigation of allegations of abuse, and provide for the safety of residents during the investigation of abuse for 1 of 3 allegations of abuse reviewed (Resident #73). Findings include: Resident #73's record was reviewed on 4/18/2013 at 12:44 P.M. A quarterly Minimum Data Set Assessment Tool (MDS), dated 3/18/2013, indicated, Resident #73 was rarely/never understood, had memory problems, unable to recall names, faces, her own room, or current season. She required supervision due to moderately impaired cognition. She made poor decisions and needed cues. During an interview on 4/17/2013 at 10:30 A.M., a family member indicated approximately three or four months ago she had witnessed a staff member take a resident by the arm and use force to make her sit in a chair. When this occurred she indicated the resident yelled out your hurting my arm. The resident got up from the chair and the CNA made her sit in another chair. She did not recall the resident's name at the time but		**accomplished for those residents found to have been affected by the deficient practice?** · Resident #73 was assessed by Memory Care Coordinator and does not exhibit any signs or symptoms of psychosocial distress. · Event was reported to the Indiana State Department of Health, Indiana State Ombudsman, and Adult Protective Services on 4/23/2013. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficient practice. · Staff will be re-educated on abuse prohibition and reporting by Staff Development Coordinator/designee by 05/24/2013. · DNS Specialist will re-educate department managers on identification, investigation and reporting by 5/24/13. · Executive Director will, with permission, attend resident council meeting monthly to discuss abuse, types of abuse, and if residents have ever been abused. · The Executive Director/designee will report and investigate all unusual occurrences, which include allegations of abuse,	

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	she indicated she reported it to the Memory Care Coordinator (MCC) and he indicated to her the CNA was new and possibly needed more training. Review of a document titled "Resident/Family Concern/Grievance Form, dated 1/14/2013 indicated on 1/14/2013, "Reported during care conference. Concerned that one of the new CNAs (Certified Nursing Assistant) was treating resident with demeaning tone/without dignity. Maybe needs more training." This form was signed by the MCC. During an interview on 4/24/2013 at 9:30 A.M., with the Executive Director (ED) and the Memory Care Coordinator (MCC) present, the MCC indicated, once he found out about the allegation he investigated it. He did not feel like it was abuse, therefore, it was not reported to State officials. At this time, he was queried regarding the facility's abuse policy. He indicated, he was aware all allegations of abuse were to be reported immediately to the Administrator and to the State. He further indicated when he was told about the situation it was later in the day and the CNA in question had already gone home. This CNA was allowed to work the next day. He		within 24 hours of discovery to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation will also be sent to Adult Protective Services and State Ombudsman. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** · Staff will be re-educated on abuse prohibition and reporting by Staff Development Coordinator/designee by 05/24/2013. · DNS Specialist will re-educate department managers on identification, investigation and reporting by 5/24/13. · Any staff member implicated in allegations of abuse will be removed from the facility at once and will remain suspended until an investigation is completed – to be overseen by the Executive Director. · The Executive Director/designee will report and investigate all unusual occurrences, which include allegations of abuse, within 24 hours of discovery to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation will also be sent to Adult Protective Services and State Ombudsman. · Executive Director will, with permission, attend resident council	

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	indicated the investigation included observations of the CNA's interactions with the residents and questioning the CNA. He indicated he was not aware of the physical part of the allegation at the time. After he talked to the CNA, she was allowed to continue working on the secured dementia unit. The ED of the facility was not informed of the situation until 1/17/13. At this time the ED did not report the allegation of abuse to the State. She indicated, the resident in question was Resident #73. A policy titled, "Abuse Prohibition, Reporting, and Investigation", provided by the Administrator on 4/18/2013 at 1:30 P.M., indicated, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse. . . verbal abuse. . . . Abuse is the willful infliction of injury. . . resulting in physical harm or pain. . . . All allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination. The Executive Director is the designated individual responsible for coordinating all efforts in the		meeting monthly to discuss abuse, types of abuse, and if residents have ever been abused. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Staff will be re-educated on abuse prohibition and reporting by Staff Development Coordinator/designee by 05/24/2013. · To ensure compliance, the DNS/Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	investigation of abuse allegations, and for assuring that all policies and procedures are followed. . . . The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. . . . Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed. . . . Resident will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented. The investigation will include: Facts and observations by involved employees, facts and observations by witnessing employees, facts and observations by witnessing non-employees, facts and observations from others who might have pertinent information, facts and observations by the supervisor or individual whom the initial report was made. . . ." 3.1-28(c) 3.1-28(d)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement written policies and procedures that prohibit the mistreatment of residents for 1 of 3 residents reviewed for abuse (Resident #73). Findings include: Resident #73's record was reviewed on 4/18/2013 at 12:44 P.M. A quarterly Minimum Data Set Assessment Tool (MDS), dated 3/18/2013, indicated, Resident #73 was rarely/never understood, had memory problems, unable to recall names, faces, her own room, or current season. She required supervision due to moderately impaired cognition. She made poor decisions and needed cues. During an interview on 4/17/2013 at 10:30 A.M., a family member indicated approximately three or four months ago she had witnessed a staff member take a resident by the arm and use force to make her sit in a	F000226	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident was assessed by Memory Care Coordinator and does not exhibit any signs or symptoms of psychosocial distress. · Event was reported to the Indiana State Department of Health, Indiana State Ombudsman, and Adult Protective Services on 4/23/2013. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficient practice. · Staff will be re-educated on abuse prohibition and reporting by Staff Development Coordinator/designee by 05/24/2013. · DNS Specialist will re-educate department managers on identification, investigation and reporting by 5/24/13. · Executive Director will, with	05/24/2013

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	chair. When this occurred she indicated the resident yelled out your hurting my arm. The resident got up from the chair and the CNA made her sit in another chair. She did not recall the resident's name at the time but she indicated she reported it to the Memory Care Coordinator (MCC) and he indicated to her the CNA was new and possibly needed more training. Review of a document titled "Resident/Family Concern/Grievance Form, dated 1/14/2013 indicated on 1/14/2013, "Reported during care conference. Concerned that one of the new CNAs (Certified Nursing Assistant) was treating resident with demeaning tone/without dignity. Maybe needs more training." This form was signed by the MCC. During an interview on 4/24/2013 at 9:30 A.M., with the Executive Director (ED) and the Memory Care Coordinator (MCC) present, the MCC indicated, once he found out about the allegation he investigated it. He did not feel like it was abuse, therefore, it was not reported to State officials. At this time, he was queried regarding the facility's abuse policy. He indicated, he was aware all allegations of abuse were to be reported immediately to the		permission, attend resident council meeting monthly to discuss abuse, types of abuse, and if residents have ever been abused. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Staff will be re-educated on abuse prohibition and reporting by Staff Development Coordinator/designee by 05/24/2013. · DNS Specialist will re-educate department managers on identification, investigation and reporting by 5/24/13. · Any staff member implicated in allegations of abuse will be removed from the facility at once and will remain suspended until an investigation is completed – to be overseen by the Executive Director. · The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, within 24 hours of discovery to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation will also be sent to Adult Protective Services and State Ombudsman. · Executive Director will, with permission, attend resident council meeting monthly to discuss abuse, types of abuse, and if residents have ever been abused. **How the corrective action(s) will be**	

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	Administrator and to the State. He further indicated when he was told about the situation it was later in the day and the CNA in question had already gone home. This CNA was allowed to work the next day. He indicated the investigation included observations of the CNA's interactions with the residents and questioning the CNA. He indicated he was not aware of the physical part of the allegation at the time. After he talked to the CNA, she was allowed to continue working on the secured dementia unit. The ED of the facility was not informed of the situation until 1/17/13. At this time the ED did not report the allegation of abuse to the State. She indicated, the resident in question was Resident #73. A policy titled, "Abuse Prohibition, Reporting, and Investigation", provided by the Administrator on 4/18/2013 at 1:30 P.M., indicated, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse. . . verbal abuse. . . . Abuse is the willful infliction of injury. . . resulting in physical harm or pain. . . . All allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Staff will be re-educated on abuse prohibition and reporting by Staff Development Coordinator/designee by 05/24/2013. · To ensure compliance, the DNS/Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. . . . The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. . . . Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed. . . . Resident will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented. The investigation will include: Facts and observations by involved employees, facts and observations by witnessing employees, facts and observations by witnessing non-employees, facts and observations from others who might have pertinent information, facts and			

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	observations by the supervisor or individual whom the initial report was made. . . ." 3.1-28(a)			

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F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure a resident's dignity was maintained during 1 of 1 dining observation as evidenced by failure to remove food debris and saliva from a resident's face and lap [Resident #61], standing to feed a dependent resident [Resident #49], and failure to maintain an environment free of signs containing personal information in 1 of 35 resident rooms reviewed for dignity concerns [Resident #6]. Findings include: 1. On 4/15/13 from 12:25 P.M. to 1:00 P.M., dining was observed on the East [long term care] unit of the facility. At that time, Resident #61 was observed. He was observed coughing and spitting large amounts of food onto his lap during the dining observation. Resident #61's chin was covered with food debris as well as saliva throughout the meal. On 4/15/13 at 12:35 P.M., Licensed	F000241	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Sign in room of Resident #6 has been removed · Resident #61 is assisted during meal service to promote care for residents in a manner and in an environment that maintains or enhances dignity and respect. · Staff members sit while providing assistance to feed a resident. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficient practice. · Signs not indicated in a resident's plan of care will be removed. Audit of rooms will be complete by interdisciplinary team to remove personal care signs not indicated in the plan of care. · Staff will be re-educated by 05/24/2013 regarding dignity and dining by Staff Development	05/24/2013

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	Practical Nurse [LPN] #1 was observed speaking to Resident #61. She told the resident to take small bits of his food; however, she failed to assist the resident in cleaning the food debris and saliva from his face and lap. On 4/16/13 at 3:00 P.M., in an interview, the Executive Director [ED] indicated that Resident #61 was recently moved from the main dining room to the East dining area because he required more supervision while eating and residents in the main dining room complained about how he ate [coughing and spitting food out]. The ED indicated staff were aware of Resident #61's needs during dining including, but not limited to, increased supervision and assistance with cleaning food and saliva from his face and lap. 2. On 4/15/13 at 12:25 P.M., Resident #49 was observed on the East unit of the facility during dining observation. At that time, Certified Nursing Aide [CNA] #3 was observed standing over the resident while assisting him with his meal. On 4/15/13 at 1:05 P.M., in an interview, CNA #3 indicated she didn't typically stand to feed residents who		Coordinator/designee · Manager on duty will ensure staff sits while providing assistance and that residents are provided a dignified eating experience. · Resident #61 will be provided extra napkins and assistance when needed to provide a dignified dining experience. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Signs not indicated in a resident's plan of care will be removed · Staff will be re-educated by 05/24/2013 regarding dignity and dining by Staff Development Coordinator/designee · Staff will round daily to ensure personal care signs are not posted in residents' rooms. · Staff will be re-educated by 05/24/2013 regarding dignity and dining by Staff Development Coordinator/designee · Manager on duty will ensure staff sits while providing assistance and that residents are provided a dignified eating experience by providing adequate amount of napkins. Staff are providing cueing, prompting, or assisting residents to eat/wipe mouth. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be**	

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	required assistance; however, she didn't want to go get a chair. 3. On 4/16/13 at 2:10 P.M., Resident #6's room was observed. At that time, the following sign was observed above the resident's bed that included, but was not limited to, "Your shower days are the following... You are not to take a shower without a staff member..." At that time, in an interview, Resident #6 indicated he wasn't aware of what the sign meant. On 4/18/13 at 10:00 A.M., in an interview, LPN #1 indicated the sign was placed to remind the resident when his shower days were scheduled; however, she indicated he didn't remember and needed daily reminders regardless of the sign. 3.1-3(t)		**put into place** · To ensure compliance, the DNS/Designee is responsible for the completion of the Dignity and Privacy CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observations, record review, and interview, the facility failed to develop a plan of care for a resident identified as having positioning issues during dining for 1 of 1 residents reviewed in the stage two sample for positioning (Resident #73). Findings: During observation of the noon meal on 4/15/2013 at 12:00 P.M., Resident #73 was observed leaning towards the right of the chair with her eyes	F000279	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #73 was assessed by therapy and then a shorter chair was provided for Resident #73 so feet can touch floor and staff re-position when needed during meals or activities. Resident has been picked up on therapy caseload for positioning · Care plan has been developed to address resident #73's positioning during meals. **How will you identify other residents having the potential to be**	05/24/2013

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	closed. LPN #21 was observed talking to her and asking her if she wanted to eat. At 12:25 P.M., Resident #73 was observed sliding down in the chair. LPN #21 was observed feeding Resident #73 while she was slumped down in the chair and leaning to the right. 12:53 P.M., a visitor (not staff) was observed feeding Resident #73 while slumped over to the left side. This visitor attempted to reposition Resident #73. Staff was observed to assist with the repositioning of Resident #73. Resident #73 was observed sitting upright in the chair. Her feet did not touch the floor. At 12:55 P.M., Resident #73 was observed sliding back down in the chair. During observations on 4/18/2013 at 11:51 A.M., Resident #73 was observed seated at the dining table slumped down in the chair. She was observed attempting to scoot herself up in the chair. She was able to reposition herself some but was unable to reach the floor with her feet. At 12:01 P.M. she was observed sliding back down the chair until her feet touched the floor. LPN #21 was observed feeding Resident #73 in the slumped position at 12:20 P.M. and 12:30 P.M. During this time of constant observation staff were not		**affected by the same deficient practice will be identified and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · Residents are screened no less than quarterly by therapy for appropriate positioning. · Therapy audit for positioning of all residents while at meals to be completed by therapists by 05/24/2013. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Residents are screened no less than quarterly by therapy for appropriate positioning. · Meal time charge nurse will observe positioning of residents throughout meal service. If any resident is observed to have positioning concerns during mealtime, care plan will be developed by IDT Team. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · To ensure compliance, the DNS/Designee is responsible for the completion of the Accommodations of Needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is	

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	observed to attempt to reposition Resident #73. During an interview on 4/18/2013 at 12:23 P.M., the Memory Care Coordinator (MCC) indicated, the positioning problem was new and they have been trying to pull her up. He indicated he believed therapy was seeing her for this problem. Resident #73's chart was reviewed on 4/18/2013 at 12:44 P.M. A quarterly Minimum Data Assessment tool (MDS) dated 3/8/2013, indicated, Resident #73 had memory problems, was cognitively impaired, and required supervisions and cues due to poor decision making. She was an extensive assist for eating and required a mechanically altered diet. Progress notes from 4/12/2013 through 4/18/2013 were reviewed. The record lacked documentation of the "new" positioning issue. A current care plan problem which originated on 10/4/2011, indicated Resident #73 required a mechanically altered diet related to swallowing difficulties. During an interview on 4/19/2013 at 10:52 A.M., The MDS/Care Plan		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 05/24/13** -	

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	Coordinator indicated, the way she found out if a resident had a new issue was via the morning meeting. She indicated Resident #73 was started on therapy's case load on 4/16/2013 due to a diagnosis of abnormality of gait. During an interview on 4/19/2013 at 11:00 A.M., Physical Therapy #22, indicated Resident #73 was not being seen for positioning. On 4/18/2013 someone had brought it to her attention that Resident #73 was leaning. They brought her to the therapy room and could not find anything wrong with her vertical alignment. At this time she was informed of the observations of Resident #73's feet not reaching the floor in dining room chair. She indicated the solution was probably as simple as getting her another chair so her feet could touch the floor. 3.1-35(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed regarding aspiration precautions and diet as ordered for 1 of 40 stage two sampled residents (Resident #75). Findings: Resident #75's record was reviewed on 4/18/2013 at 9:17 A.M.. Resident #75 had diagnoses which included, but were not limited to, Alzheimer's disease, severe dementia with progressive decline, and a history of urinary tract infections. A physician's order dated 7/3/2011, indicated Resident was to have straws with all liquids. A physician's order dated 12/12/12, indicated she was to have a regular diet with fortified foods and cranberry juice three times daily. An occupational therapy note dated 1/22/1013, indicated Resident #75 required maximum assistance for	F000282	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #75 was screened by Speech Language Pathologist and determined that straw was not indicated and was discontinued per order. Physician's order for cranberry juice was discontinued based on resident preference. Care plan revised. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident residing in the facility have the potential to be affected by the alleged deficiency. · Nursing and dietary staff will be re-educated on transmission of diet orders by SDC/CDM/designee by 05/24/2013 · Staff will be re-educated on reading tray tickets for residents to ensure appropriate interventions and diet by SDC/CDM/designee by 05/24/2013. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur**	05/24/2013

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	feeding and had advanced dementia with no knowledge of recent events. Resident #75 was observed on 4/18/2013 at 10:03 A.M. during an activity. At 10:10 staff sat down with her and gave her a drink out of a coffee cup with no straw. She was observed giving her another drink without a straw at 10:13 A.M. and 10:14 A.M. A current care plan dated 2/25/2013, indicated Resident #75 required an eating/swallowing program due to impaired cognition. Staff were to observe for symptoms of aspiration. She also had difficulty chewing and swallowing and required straws with all liquids. During a dining observation on 4/18/2013 at 1:09 P.M., Certified Nursing Assistant (CNA) # 23 was observed feeding Resident #75. Resident #75 was served chocolate milk and water. No cranberry juice was observed on the tray. CNA #23 attempted to give Resident #75 a drink of water with no straw. Resident #75 pushed her hand away. At this time CNA #23 was asked"how Resident #75 tolerated her fluids. She replied, "Well, I tried to give her a drink of water and she pushed my		· Nursing and dietary staff will be re-educated on transmission of diet orders by SDC/CDM/designee by 05/24/2013. · Staff will be re-educated on reading tray tickets for residents to ensure appropriate interventions and diet by SDC/CDM/designee by 05/24/2013. · Nursing will complete Diet Communication Form when there are changes in physician's orders for changes in orders. · Manager on duty will monitor tray tickets for accuracy during meal service. · CDM/designee will audit diet orders by 5/24/13 to ensure they match tray tickets. · Dining room manager will utilize Dining Room Manager Observation Checklist 3 times a week until compliance is achieved. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · To ensure compliance, the DNS/Designee is responsible for the completion of the Meal Service Observation-CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If	

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	hand away." On 4/19/2012 at 1:04 P.M., Resident #75 was observed being fed lunch. Chocolate milk, purple color fluid, and water were observed on her tray. No cranberry juice was observed on her tray. During an interview on 4/19/2013 at 1:15 P.M., Dietary staff #24 indicated, LPN (Licensed Practical Nurse) #25 told her a few weeks ago that Resident #75 did not like cranberry juice and we were not to give it to her. During an interview on 4/19/2013 at 1:27 P.M., LPN #25 indicated she had told dietary staff she didn't like cranberry juice however, she did not tell them to take it off the ticket. She was going to contact the daughter and the physician to see if they could get her something else besides cranberry juice. She indicated she fed Resident #75 breakfast and she would spit the cranberry juice at her. 3.1-35(g)(2)		threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 05/24/13**	

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	155383	A. BUILDING 00 B. WING	04/24/2013

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observations, record review, and interview, the facility failed to provide proper positioning for 1 of 10 residents reviewed for position during dining for 2 of 2 dining observations (Resident #73). Findings: During observation of the noon meal on 4/15/2013 at 12:00 P.M., Resident #73 was observed leaning towards the right of the chair with her eyes closed. LPN #21 was observed talking to her and asking her if she wanted to eat. At 12:25 P.M., Resident #73 was observed sliding down in the chair. LPN #21 was observed feeding Resident #73 while she was slumped down in the chair and leaning to the right. 12:53 P.M., a visitor (not staff) was observed feeding Resident #73 while slumped over to the left side. This visitor attempted to reposition Resident #73. Staff was observed to assist with the repositioning of Resident #73.	F000309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #73 was assessed by therapy and then a shorter chair was provided for Resident #73 so feet can touch floor and staff re-position when needed during meals or activities. Resident has been picked up on therapy caseload for positioning · Care plan has been developed to address resident #73's positioning during meals. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · Residents are screened no less than quarterly by therapy for appropriate positioning. · Therapy audit for positioning of all residents while at meals to be completed by therapists by 05/24/2013.	05/24/2013

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	Resident #73 was observed sitting upright in the chair. Her feet did not touch the floor. At 12:55 P.M., Resident #73 was observed sliding back down in the chair. During observations on 4/18/2013 at 11:51 A.M., Resident #73 was observed seated at the dining table slumped down in the chair. She was observed attempting to scoot herself up in the chair. She was able to reposition herself some but was unable to reach the floor with her feet. At 12:01 P.M. she was observed sliding back down the chair until her feet touched the floor. LPN #21 was observed feeding Resident #73 in the slumped position at 12:20 P.M. and 12:30 P.M. During this time of constant observation staff were not observed to attempt to reposition Resident #73. During an interview on 4/18/2013 at 12:23 P.M., the Memory Care Coordinator (MCC) indicated, the positioning problem was new and they have been trying to pull her up. He indicated he believed therapy was seeing her for this problem. Resident #73's chart was reviewed on 4/18/2013 at 12:44 P.M. A quarterly Minimum Data Assessment tool		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Residents are screened no less than quarterly by therapy for appropriate positioning. · Meal time charge nurse will observe positioning of residents throughout meal service. If any resident is observed to have positioning concerns during mealtime, care plan will be developed by IDT Team. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · To ensure compliance, the DNS/Designee is responsible for the completion of the Accommodations of Needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 05/24/13**	

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	(MDS) dated 3/8/2013, indicated, Resident #73 had memory problems, was cognitively impaired, and required supervisions and cues due to poor decision making. She was an extensive assist for eating and required a mechanically altered diet. During an interview on 4/19/2013 at 11:00 A.M., Physical Therapy #22, indicated Resident #73 was not being seen for positioning. On 4/18/2013 someone had brought it to her attention that Resident #73 was leaning. They brought her to the therapy room and could not find anything wrong with her vertical alignment. At this time she was informed of the observations of Resident #73's feet not reaching the floor in dining room chair. She indicated the solution was probably as simple as getting her another chair so her feet could touch the floor. 3.1-37(a)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure a resident was adequately evaluated prior to starting the anti-psychotic medication Risperidol. This deficient practice affected 1 of 10 residents reviewed for unnecessary medication use [Resident #6]. Findings include: On 4/18/13 at 10:10 A.M., Resident #6's record was reviewed. Diagnoses	F000329	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #6 will have a psych referral for medication review by 5/24/13. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by this alleged deficient	05/24/2013

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	included, but were not limited to, hemiplegia/hemiparesis [limb dependent weakness], intracranial hemorrhage, epilepsy, diabetes mellitus type 2, colon cancer, hypertension, vascular dementia, depressive disorder, psychosis, and aphagia. A Medication Administration Record, dated 2/1/13 through 2/28/13, included, but was not limited to, "Risperidol [anti-psychotic medication] 0.5 mg [milligrams] po [by mouth] every PM for dementia with delusions and aggression... marked as first dose given on 2/15/13. Resident #6's progress notes for the dates of February 1, 2013 through February 6, 2013, indicated Resident #6 did not exhibit any aggressive or delusional behaviors during that time. A progress notes, dated 2/7/13 at 8:15 A.M., included, but was not limited to, "This resident was propelling backwards in his wc [wheelchair] going up incline in the hall when he backed into another resident's wc... Other resident became upset and used her elbow to hit this resident [Resident #6]... Residents were separated imm [immediately] and redirected... 15 min		practice. · IDT will provide physicians information regarding any residents' behaviors prior to prescribing an antipsychotic medication. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Facility will conduct monthly behavior meetings, overseen by the ED, to reduce use of antipsychotics in facility. The plan will include measures such as: 1) Monthly behavior meetings. The emphasis of this meeting will include re-evaluation of antipsychotic medications and improving non-pharmacological, individualized interventions. 2) Facility will utilize psych services, pharmacy consultants, doctors, psychiatrists, and nurse practitioners in facility. 3) Social Services will audit the behavior program to ensure that resident behaviors are clearly and specifically communicated on the care plan with clear, individualized, non pharmacological interventions in place for each behavior. 4) Staff education as to the Behavior Management Program with emphasis on how to react to a behavior including individualized interventions by SSD/designee by 05/24/13. Efforts to focus on behaviors as a means of communicating a need.	

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	checks..." Resident #6's progress notes from February 7, 2013 through February 13, 2013 at 2:59 A.M., indicated Resident #6 did not exhibit any aggressive or delusional behaviors. Therefore, Resident #6's non-pharmacological interventions of immediately separating him from the other resident and redirecting him were successful. A progress notes, dated 2/13/13 at 11:05 A.M., included, but was not limited to, "At about 8:45 A.M., this resident [Resident #6] was coming out of his room in his wheelchair... [other resident] was sitting in hallway... This resident [Resident #6] approached the hallway... Other resident backed up in his wheelchair into the path of this resident [Resident #6]... This resident [Resident #6] swung his arm at other resident... Staff immediately separated the residents... SSD [Social Service Director] spoke with this resident [Resident #6], who verbalized that he felt threatened..." Resident #6's progress notes from February 13, 2013 at 2:23 P.M. to April 24, 2012 at 12:00 P.M., indicated Resident #6 did not exhibit		5) Staff will complete New/Worsening Behavior Report for each behavior that is 1) a behavior that is new 2) a behavior that is directed toward another resident 3) a behavior that is increasing in either severity or frequency. 6) IDT reviews of New/Worsening behaviors will be completed on a consistent basis for residents who exhibit 1) a behavior that is new 2) a behavior that is directed toward another resident 3) a behavior that is increasing in either severity or frequency. This review will include the following: an evaluation of medical factors (recent medication changes, potential adverse side effects to medication, possible pain issues, possible infection or other medical problems); evaluation of any environment triggers; any psychosocial distress that may be occurring; consulting with the family or resident to gain insight into previous routines, behaviors and effective interventions. 7) New/Worsening or changed behaviors are communicated to clinicians and family. Non-pharmacological interventions are reviewed and implemented after discussions. 8) New orders for antipsychotic medications are reviewed during huddles. IDT will ensure that 1) an IDT note has been written on the behavior (as well as a	

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	any aggressive or delusional behaviors. Therefore, Resident #6's non-pharmacological intervention of separation from the other resident was successful. A "Psychiatric Progress Notes" dated 2/13/13, no time, included, but was not limited to, "Staff report two separate, isolated incidents... [Other] resident bumped into resident's [Resident #6] wheelchair... Patient became agitated and began swinging at [other resident]... [Other resident] responded in same way... Nursing reported another incident... [Resident #6] hit another male resident who he [Resident #6] perceived was in his way... Diagnosis: Vascular dementia with depression, agitation... Will restart Risperidol 0.5 mg [started on 2/15/13]..." Resident #6 only had 2 incidents where he became agitated related to the actions of other residents. His non-pharmacological interventions were effective; however, the facility started Resident #6 on an anti-psychotic medication for agitation. A "Behavioral Care Plan," dated 2/14/13, included, but was not limited to, "Has episodes of aggression to		New/Worsening Behavior Report if applicable) 2) a care plan is in place describing that behavior with individualized non pharmacological interventions that have been communicated effectively with the staff 3) the behavior is being monitored 4) the dose is the lowest and for the shortest time possible. 9) Monthly behavior summaries will be completed for each resident receiving antipsychotic medication. The summary will focus on evaluating and improving non pharmacological, individualized interventions in response to resident behaviors. 10) A GDR tracker is used to ensure that GDR requests are being submitted for antipsychotics at minimum every six months. GDR to be attempted annually unless clinically contraindicated by physician. · Staff education as to the Behavior Management Program with emphasis on how to react to a behavior including individualized interventions by SSD/designee by 05/24/13. Efforts to focus on behaviors as a means of communicating a need. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · To ensure compliance, the DNS/Designee is responsible for the	

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	others as evidenced by hitting, kicking, and yelling/cursing... Contributing dx [diagnosis] of dementia with delusions and aggression... Approach [2/14/13]: Address calmly by calling him chief crazy horse... Remove resident from immediate situation while validating his feelings... Redirect resident to another topic of conversation/activity, looking at an Elvis book or listening to Elvis music, Medications per md [Medical Doctors] orders..." On 4/19/13 at 10:20 A.M., in an interview, Licensed Practical Nurse [LPN] #1 indicated Resident #6 was referred to [local psychiatric physician] related to the 2 incidents and placed on Risperidol. LPN #6 indicated she was unaware of any other aggressive behaviors prior to the 2 incidents in February, 2013. On 4/23/13 at 2:30 P.M., in an interview, the Director of Nursing and the Social Service Director indicated they were unable to speak directly to [prescribing physician]; however, his nurse practitioner indicated Resident #6 was placed on Risperidol related to his increased aggression as evidenced by the 2 reported incidents in February, 2013.		completion of the Behavior Management CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date:** 05/24/13	

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	On 4/24/13 at 12:00 P.M., the Executive Director indicated she had no further documentation to provide regarding Resident #6's aggressive behaviors. 3.1-48(b)(2)			

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F000334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure education, which included, the benefits and potential side effects of the influenza vaccination was provided to 5 of 5 residents reviewed for annual receipt of influenza education (Resident #68, #75, #84, #99, and #2). Findings include: During an interview on 4/19/13 at 10:22 A.M., the Infection Control Nurse indicated, the following residents had received and/or	F000334	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents #68, #75, #84, #99, and #2 will receive education regarding benefits and potential side effects of the influenza vaccine when offered to the residents during the next flu season. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficiency.	05/24/2013

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	declined the flu vaccination for the 2012/2013 flu season: Resident #68, Resident #75, Resident #84, Resident #99, and Resident #2. During this interview, he was queried regarding the process of informing residents and/or family members on the risk and benefits of vaccinations. He indicated, the education was provided on the consent/declination form. The facility's consent/declination form was reviewed on 4/19/2013 at 10:25 A.M. The form indicated, ". . .I hereby give the facility permission to administer an influenza vaccination annually, between Oct 1 and March 31. I have been instructed that as a result of this vaccination, I may experience some side effects such as: slight discomfort, soreness of the arm, redness of the arm, slight fever occasionally), muscle aches (occasionally) . . . ." The information did not contain education which included the benefits and potential side effects in accordance with the Center for Disease Control (CDC) guidance. During an interview on 4/23/2013 at 1:00 P.M., the Infection Control Nurse indicated, he thought they had a pamphlet that was sent out with the CDC information but did not have		· Before offering the influenza immunization, each resident/or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization based upon up-to-date CDC information. · Each resident will be offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. · The resident or the resident's legal representative has the opportunity to refuse immunization · The resident's medical record includes documentation that indicates, at a minimum, the following: a) that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and b) that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. · DNS will re-educate SDC on ensuring residents are educated on benefits and potential side effects of influenza vaccine during October 1 through March 31. **What measures will be put into place or what systemic changes you will make to ensure that the**	

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	documentation which indicated it was done. Review of a policy titled "Influenza Vaccine," provided by the Infection Control Nurse on 4/23/2013 at 1:05 P.M., indicated, ". . .Each resident and/or responsible party will receive education regarding the vaccine based upon up to date CDC information. . ." 3.1-18(a)		**deficient practice does not recur** · Before offering the influenza immunization, each resident/or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization based upon up-to-date CDC information. · Each resident will be offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. · The resident or the resident's legal representative has the opportunity to refuse immunization · The resident's medical record includes documentation that indicates, at a minimum, the following: a) that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and b) that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. · DNS will re-educate SDC on ensuring residents are educated on benefits and potential side effects of influenza vaccine during October 1 through March 31. · Medical Records Nurse will audit the influenza consent forms during flu season to ensure residents	

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	155383	A. BUILDING 00 B. WING	04/24/2013

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			were provided benefits and potential side effects of vaccine and up-to-date CDC guidelines. Updated form to include confirmation of receipt benefits and potential side effects based on up-to-date CDC guidelines. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · To ensure compliance, the DNS/Designee is responsible for the completion of the Resident Immunizations CQI tool will be reviewed monthly for compliance from October through March. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 05/24/13**	

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F000364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on interview and observation, the facility failed to serve food at the appropriate temperature to ensure resident satisfaction. This deficient practice affected 2 of 35 residents reviewed for food quality who received food from 1 of 1 facility kitchen [Residents #77 and #26]. Findings include: 1. On 4/15/13 at 2:06 P.M., in an interview, Resident #77 indicated by the time she gets her food it was cold. 2. On 4/16/13 at 12:28 P.M., in an interview, Resident #26 indicated the food was not kept hot upon delivery to the West [rehabilitation] unit dining area. He indicated food such as hot dogs were always cold. On 4/23/13 at 12:47 P.M., food temperatures were checked by the Dietary Manager [DM] from a test tray delivered to the East dining area. At that time, the sausage was recorded at 125.6 degrees Fahrenheit. At that	F000364	**F364 - Food Temperatures** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents #77 and #26 are receive food at palatable and appropriate temps as monitored by dietary staff taking temperatures of meals to ensure food is served at an acceptable range. · Food temperatures are taken at each meal to ensure food temperatures are within the acceptable range. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficiency. · Dietary staff will be re-educated on monitoring/documenting food temperature by 05/24/2013. · Dietary staff will take temperatures at the beginning of meal service and periodically during meal service to ensure acceptable range during the	05/24/2013

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	time, in an interview, the DM indicated the temperature of the sausage should have been at 140 degrees Fahrenheit. 3.1-21(a)(2)		portioning, transporting, and service process until received by the resident. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Dietary staff will be re-educated on monitoring/documenting food temperature by 05/24/2013. ·Food temperatures are checked daily at each meal and recorded on a food temperature log by food service personnel to ensure that foods are served at the appropriate temperatures. This log is reviewed by CDM/designee. If food is not at appropriate temperatures, corrective action is taken. CDM/designee will review temperature log at each meal. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · To ensure compliance, the DNS/Designee is responsible for the completion of the Meal Service Observation CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If	

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			threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 05/24/13**	

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to properly store opened foods with labels, open dates, and or expiration dates for 1 of 2 kitchen observations. Findings: Observations of the facility's dry and cold food storage were made on 4/15/2013, beginning at 9:15 A.M. Cook #55 was present for the observations. A jar of opened honey was not marked with an open date. An opened bag of taco seasoning was not marked with an open date. A package of opened Salisbury steaks was not labeled with an open/expiration date. An unlabelled plastic bag containing an unidentifiable dough, identified as cinnamon rolls by cook #55, did not have an open or expiration date. An opened and unlabelled plastic bag of sausage patties, did not have an open date or expiration date. A container with a liquid substance was	F000371	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were identified to be affected by the alleged deficient practice. · All undated food in kitchen area was discarded. **How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficient practice. · Noncompliance may result in employee 1:1 education and/or disciplinary action. · Dietary staff will be re-educated on labeling and date procedures by the Dietary Manager by 05/24/13. · Audit conducted by CDM/designee to ensure foods are covered, labeled, and dated with an open/expiration date. CDM/designee to supervise.	05/24/2013

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	not labeled with an open or expiration date. Cook #55 indicated she thought it was low calorie juice. An opened package of pepperoni did not have an open date. During an interview on 4/15/2013 at 9:25 A.M., Cook #55 indicated all items should be labeled and dated with an open date and an expiration date. A facility policy provided by Cook #55 on 4/15/2013 at 9:45 A.M., indicated, ". . .All opened and leftover items need to be labeled with the date of opening/date stored and a discard/use-by date. . . ." 3.1-21(i)(3)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Noncompliance may result in employee 1:1 education and/or disciplinary action. · Dietary staff will be re-educated on labeling and date procedures by the Dietary Manager by 05/24/13. · CDM/designee will check food storage areas daily to ensure opened items have been labeled with open dates and date of expiration. To be monitored by ED. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Dietary staff will be re-educated on labeling and date procedures by the Dietary Manager by 05/24/13. · Noncompliance may result in employee 1:1 education and/or disciplinary action. · RD/CDM will do full sanitation review monthly and short-form sanitation forms weekly until 100% compliance. Dietary manager/designee will monitor compliance. **Compliance date: 05/24/13**	